5.09: continued

i. In order for the interest related to the financing of a newly acquired fixed asset to be considered for reimbursement, the acquisition and financing must occur concurrently, except that a grace period of not more than 90 days between the date of acquisition and financing is permitted if the Provider can present sufficient documentation to support its claim that all reasonable attempts were made to finance the asset at the time of the acquisition.

ii. The Division will not allow interest expense on loans to the facility from an owner, officer, or Related Party.

iii. The Division will not offset interest income against interest expense.

iv. Mortgage Acquisition Costs. Mortgage Acquisition Costs must be amortized over the life of the mortgage. Amortized mortgage acquisition costs are treated as Long Term Interest Expense. For allowable Long-Term debts secured on or after January 1, 1983, Mortgage Acquisition Costs are subject to the provisions of maximum interest rates and permanent factors, if applicable.

b. Refinancing. The Division will recognize the refinancing of an existing allowable debt as an allowable debt under the following circumstances:

i. Crossover. When the accumulated principal payments on the existing, allowable debt exceeds the accumulated depreciation allowed by the Division on the allowable fixed assets which have been financed by that debt; or

ii. Demand Note. When an existing, allowable debt becomes payable upon demand; or

iii. Lowered Expense. When the Long-Term Interest Expense over the life of the refinanced debt is lower than it would have been under the remainder of the existing, allowable debt. The Provider must submit comparative schedules showing total Long-Term Interest Expense under both the existing, allowable debt and the re-financed debt.

iv. Financing of Allowable Additions. When a Provider refinances for amounts greater than the existing, allowable debt and the additional indebtedness is used for a significant addition of allowable depreciable fixed assets. If the refinancing is for amounts greater than the existing, allowable debt on the date of the refinancing and the additional indebtedness is used for purposes other than a significant addition of allowable depreciable fixed assets, the Division will not reimburse interest expense on the additional indebtedness. When a Provider refinances for amounts greater than the existing, allowable debt on the date of refinancing and the additional indebtedness is used for the addition of allowable depreciable fixed assets which are not significant, only the portion of the refinancing related to the financing of the newly acquired fixed assets will be allowable.

c. Non-recognized Debt. If the refinanced debt is not allowable, the Division will continue to include in the rates the amount of Long Term Interest Expense which would have been incurred on the prior allowable debt. The amount of reimbursement will not exceed the amount of Long-Term Interest Expenses actually incurred by the Provider.

2. Permanent Factor for Interest. The Division will reimburse interest on an allowable debt to the extent that such debt is supported by depreciable fixed assets. Land and Mortgage Acquisition Costs are not depreciable fixed assets. The Division will calculate the percentage of allowable debt to total debt by dividing the allowable basis of depreciable fixed assets by the total amount of the debt. Upon refinancing, the Division will recalculate the Permanent Factor by dividing the prior allowable mortgage balance by the total amount of the new debt.

3. Allowable Interest Rate.

a. Allowable long-term debts secured prior to January 1, 1983. The allowable interest rate on the allowable debt is the lower of

i. an annually determined percentage of simple interest on all outstanding long-term loans weighted by the dollar amount borrowed, or

ii. the interest rate(s) as stated in the debt instrument(s) at the time of borrowing.

5.09 continued

iii. The Division will not reimburse an interest rate in excess of 18% for any individual loan or obligation. Except for facilities that were granted advisory rulings concerning Long Term Interest Expense prior to January 1, 1983, the aggregate or weighted rate of interest may not exceed 15%.

b. Allowable long-term debts secured on or after January 1, 1983. The allowable interest rate is the lower of:

i. the percentage of total Long-Term Interest Expense divided by the average outstanding principal during the reporting period, or

ii. the annual percentage rate on special issues of the public debt obligations issued by the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing was incurred plus 3%. iii. The Division will not reimburse an interest rate in excess of 18% on any individual loan or obligation.

iv. The allowable interest rate applies throughout the life of any debt and will continue to apply if the Provider refinances an allowable debt which is not recognized under 114.2 CMR 5.09(3)(d)1.b.

(e) Calculation of Base Year per diem for Allowable Capital and Other Fixed Costs.

1. The Division will calculate total Allowable Base Year Capital and Other Fixed Costs by adding allowable depreciation, allowable Long Term Interest Expense, Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment; the Non-Income portion of the Massachusetts Corporate Excise tax; Building Insurance; and Rental of Equipment located at the facility.

2. The Division will calculate Allowable Fixed Costs *per diem* by dividing Allowable Base Year Capital and Other Fixed Costs by the Constructed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Base Year.

(4) Method Two. Providers reimbursed under Method Two will receive a Capital Allowance in lieu of all capital and other fixed costs.

(a) For rates effective January 1, 1997, the allowance is $5.61 *per diem*.

(b) Transition Period Capital Allowance for Rates Effective January 1, 1997.

1. The Division will calculate each Provider's Allowable Base Year *per diem* Capital and Other Fixed Costs which include allowable depreciation, Financing Contribution and other allowable Fixed Costs.

a. Depreciation. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvement	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

b. Financing Contribution. The Financing Contribution is calculated by applying the Federal Hospital Trust Fund rate effective October, 1995, or 6.375%, to the Allowable Book Value at the end of the Base Year. The Allowable Book Value is the allowable basis less all accumulated depreciation allowed in rates of payment for Publicly-Aided Residents, except allowed Building depreciation expense which occurred between January 1, 1983 and December 31, 1992

c. The Division will calculate reasonable Base Year Capital and Other Fixed Costs by adding allowable depreciation, the financing contribution, Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment ,the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility

5.09 continued

d. The Division will calculate Allowable Base Year *per diem* Capital and Other Fixed Costs by dividing reasonable Base Year Costs by the Constructed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Base Year. Allowable Base Year *per diem* Capital and Other Fixed Costs may not exceed $16.00 *per diem*.

2. If the Provider's Base Year *per diem* Capital and Other Fixed Costs exceeds the Capital Allowance, the Transition Period Capital Allowance will be the lower of $13.40 or the sum of the Capital Allowance plus 75% of the difference between such allowance and the facility's Base Year *per diem* Capital and Other Fixed Costs.

3. If the Provider's Base Year *per diem* Capital and Other Fixed Costs is less than the Capital Allowance, the Capital Allowance will be the facility's Base Year *per diem* Capital and Other Fixed Costs plus 30% of the difference between the Capital Allowance and the facility's Base Year *per diem* Capital and Other Fixed Costs.

(c) Facilities that are leased or rented. The Base Year *per diem* Capital and Other Fixed Costs for the real property of a Nursing Facility that is leased or rented is limited to the lower of the following:

1. Actual rental expenses paid;
2. Average rental or ownership costs of comparable Providers; or
3. The transition period capital allowance determined pursuant to 114.2 CMR 5.09(4)(b).

5.10: Equity and Use and Occupancy Allowance

The Division will include a return on Average Equity Capital for Proprietary Providers that are reimbursed for Capital and Other Fixed Costs under Method One. The Division will include a Use and Occupancy Allowance for certain Non-Profit Providers that are reimbursed for Capital and Other Fixed Costs under Method One.

(1) Average Equity Capital. Average Equity Capital is the average of the difference between the Provider's Allowable book value of Fixed Assets at the beginning and end of the year as determined under 114.2 CMR 5.09, and the Provider's allowable long-term liabilities at the beginning and end of the year. For equity, allowable long-term liabilities are total allowable debt supported by total allowable assets, including land.

(a) The Division will reduce Average Equity Capital by Building Depreciation allowed in prior years except for the allowable Building Depreciation expenses which occurred between January 1, 1983 and December 31, 1992. The Division will also reduce Average Equity Capital by depreciation allowed on Improvements, Equipment, and Software.

(b) The Division will not include Mortgage Acquisition Costs, such as capitalized legal fees and prepaid interest on long-term obligations, or equity in Buildings and/or Equipment not located at the Nursing Facility, in Average Equity Capital.

(c) The Division will not reduce Average Equity Capital by long-term loans for which interest has been excluded.

(d) Equity Supplement. The Division will include an Equity Supplement in the Average Equity Capital calculation of Providers operational in the period from July 1, 1976 through December 31, 1982, and which have not had a Change of Ownership after January 1, 1983. The Equity Supplement is an amount equal to the annual Building depreciation allowed by the Division, incurred from July 1, 1976, or the date of construction of the facility, or the date of acquisition of the facility by the current owner, whichever is later, through December 31, 1982.

(e) If a facility replaces beds, reimbursable equity will be recomputed using the newly established allowable fixed assets and allowable debt, exclusive of equity supplement, if any, which was previously granted for the structure to be replaced by the new construction.

(f) Calculation of Average Equity Capital Allowance. The average equity capital allowance is calculated by multiplying Average Equity Capital by 7.875%.

(g) The Division will calculate allowable Average Equity Capital *per diem* by dividing the Average Equity Capital Allowance by the current Licensed Bed Capacity for the Rate Year, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate in the Base Year.

5.10: continued

(2) Use and Occupancy Allowance for Non-profit Providers.

(a) The Division will include a Use and Occupancy Allowance in the rates of Non-Profit Providers that have maintained a public occupancy rate, including Medicaid, Massachusetts Commission of the Blind, and Medicare Patient Days, of at least 70%.

(b) The Division will calculate the Use and Occupancy Allowance by using the methodology set forth in 114.2 CMR 5.10(1) and dividing the result by three.

(c) The Division will calculate an allowable Use and Occupancy *per diem* by dividing the Use and Occupancy Allowance by the current Licensed Bed Capacity for the Rate Year, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate in the Base Year.

5.11: New Facilities and Major Additions

(1) Projected Rates. The Division will calculate projected rates for New Facilities, Facilities with Major Additions, and Facilities which convert to Nursing Facility Use in the Rate Year.

(a) Projected Cost Report. The Provider must submit a projected cost report which projects its costs and patient days for a 12-month period commencing with the first date of licensure.

(b) Effective Dates. Projected Rates will be effective from the first date of licensure. If the Projected Rates become effective prior to July 1, the rate will be effective through December 31 of the first Rate Year. If the Projected Rates become effective after July 1, the rates will be effective through the end of the second Rate Year.

(c) Projected Rate Methodology. The Division will calculate projected rates using the lower of the Provider's projected costs as follows:

1. Nursing and Director of Nurses Costs: the lower of projected costs or the 1994 industry-wide median cost per minute inflated by 7.75%;

2. Variable Costs: the lower of projected costs or the 1994 industry-wide median Variable Costs inflated by 7.75%;

3. Administrative and General Costs: the lower of projected costs or the 1993 Base Year Median Costs inflated by 5.52%;

4. Allowable Basis of Fixed Assets: For New Facilities and Facilities with Major Additions, allowable construction costs will be limited to the Maximum Capital Expenditure amounts as approved by the Department. If the Department amends the approved Maximum Capital Expenditures for any category more than one year after the facility or any portion of the facility has become operational, the Division will not retroactively adjust rates already set to reflect the amendment.

Example: Where a New Facility or Major Addition is opened and at least one bed has been licensed as of August 15, 1996 and final costs have been submitted to the Department on September 3, 1997, the additional costs will not be applied retroactively but rather, will be recognized in the rates set for the following calendar year.

(2) Facilities which opened before December 31, 1994.

(a) Look Back Rates. The Division will calculate audited look-back rates for the period from the date of opening to the end of the first full year of operation. The first full year of operation is the first full calendar year in which the provider operated at its full licensed bed capacity.

1. Cost Base. The rates will be calculated using the cost report for the look back rate year.

2. Ceilings. The ceilings are based on industry-wide costs for the rate year calculated pursuant to the methodology in regulation effective in that year.

3. Fixed Costs. For a period not to exceed the first 12 months of operation, Allowable Capital and Other Fixed Costs will be divided by the greater of actual patient days or 96% of Maximum Available Bed Days.

(b) Off-Base Rates. The Division will calculate Off-Base Rates for each year after the facility's first full year of operation until the facility has a full year of operation in an industry-wide Base Year.

5.11: continued

1. Cost Base. The rates will be calculated using the cost report for the first full year of operation inflated by the appropriate Cost Adjustment Factor.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings inflated by the appropriate Cost Adjustment Factor.

(3) Facilities which opened on or after January 1, 1995.

(a) Look back Rates. The Division will calculate audited look-back rates for the period in which Projected Rates were in effect. This look back period will not exceed 18 months.

1. Cost Base. The rates will be calculated using the cost report for the look back rate year.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings adjusted by the appropriate Cost Adjustment Factor.
3. Fixed Costs. Unless the Provider is reimbursed for Capital and Other Fixed Costs under Method Two, for a period not to exceed the first 12 months of operation, Allowable Capital and Other Fixed Costs will be divided by the greater of actual Patient Days or 96% of Maximum Available Bed Days for the look-back period.

(b) Off-Base Rates Before July 1. If the facility opened before July 1, the Division will calculate an audited Off-Base Year rates for the second year of operation.

1. Cost Base. The rates will be calculated using the costs from the cost report for the first year of operation.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings inflated by the appropriate Cost Adjustment Factor.

(c) Off-Base Rates On or After July 1. If a facility opened on or after July 1, the Division will calculate an audited off Base Year rate for the third year of operation.

1. Cost Base. The rates will be calculated using the costs from the cost report for the second year of operation.
2. Ceilings. The ceilings are the industry-wide Base Year ceilings inflated by the appropriate Cost Adjustment Factor.

5.12: Administrative Adjustments

(1) Administrative Adjustment to Prospective Rates of Payment. A Provider may petition for an administrative adjustment to its rates only for circumstances set forth in 114.2 CMR 5.12.

(2) Requirements for Administrative Adjustments.

(a) A petition for an administrative adjustment must include the following:

1. The Provider's name, address and the rates assigned by the Division;
2. A detailed explanation, under oath, of the basis upon which said increase is sought;
3. A demonstration that an increase in specific costs are not already compensated by other portions of the prospective rates;
4. Information sufficient for the Division to determine the appropriate Cost Center for the expenditure for which reimbursement is claimed

(b) The petitioner must provide any other information which the Division requires. If the petitioner fails to provide information requested by the Division within 30 days of such request, the Division will deny the petition.

(c) The Division will suspend review of any petition if the Provider has failed to submit reports or other information required by 114.2 CMR 5.03 in a timely manner. If the Provider fails to file the required information within 60 days after notification by the Division, the Division will dismiss the petition for administrative adjustment.

(d) The Division will suspend review of any petition if the Department notifies the Provider that it has identified a quality of care problem.

(e) The Division will review petitions in accordance with the criteria set forth in the regulation in effect in the year in which they are received by the Division, notwithstanding the effective date which is prescribed by 114.2 CMR 5.12(5).

5.12: continued

(3) Standard of Review. In reviewing petitions, the Division will take into consideration the following:

(a) Whether the administrative adjustment amount would result in a significant difference in the rates;

(b) The costs of other Providers offering the same or comparable level of care;

(c) Consistency of cost increases whether for wages, nursing costs per Management Minutes, or other cost levels during the period; and

(d) The collectibility of over-payments by the Division of Medical Assistance. The Division will notify the Division of Medical Assistance of the petition.

(4) Effective Date. An administrative adjustment will be effective on the later of the date the petition was filed with the Division or the date on which the actual petitioned event occurred, whichever is later.

(5) Types of Petitions.

(a) Substantial Capital Expenditures. A Provider may petition for an administrative adjustment for a substantial capital expenditure if the Provider has either made, or expects to make, a substantial capital expenditure for a single project which meets the criteria set forth below. If the Provider has not yet incurred the expense, it must submit satisfactory evidence of its commitment to incur the expenditure. The Provider may petition for recognition of increased depreciation and interest expense as a result of the expenditure. The Provider may not petition for Mortgage Acquisition Costs or for an equity adjustment.

1. Expenditures not subject to Determination of Need. The amount of the expenditure must be at least five times the allowable annual Base Year depreciation expense. For Building cost, the expenditure must be at least five times the allowable Base Year depreciation on Building and existing Improvements. For Improvements, the expenditure must be at least five times the allowable Base Year depreciation on Improvements. For Equipment, the expenditure must be at least five times the allowable Base Year depreciation on Equipment.

2. Substantial Capital Expenditures Subject to Determination of Need. If the capital expenditure is subject to Determination of Need approval, the Provider may petition for an administrative adjustment after the Department has determined that need exists for the project and after the time for making an appeal to the Health Facilities Appeals Board has expired or all administrative and judicial reviews of the Department's determination have been concluded. The Provider may petition for an adjustment before the Department has made a determination on the project if the Commissioner of Public Health requests that the Division determine the appropriate amount of an adjustment before a Determination of Need is made with respect to the expenditure or change proposed by the Provider.

(b) New Governmental Requirements. A Provider may petition for an administrative adjustment if it has incurred, or presents satisfactory evidence of a commitment to incur, substantially different costs necessary to satisfy new requirements of a governmental Unit of the Commonwealth or of the federal government provided that the new requirements are related to resident care. An increase in existing governmental requirements is not considered a new government requirement. The Division will not grant a request for an administrative adjustment for costs incurred to correct Department of Public Health resident care deficiencies.

(c) Certain Increases in Operating Costs. A Provider may petition for an administrative adjustment if it has experienced unusual and unforeseen increases in operating costs which are not reflected in the rates. Unusual and unforeseen circumstances are events of catastrophic nature (*i.e.* fire, flood, or earthquake). The cost increases must gravely threaten the financial stability of the Provider. In measuring the degree to which the financial stability of the Provider is gravely threatened, the Division will consider all of the Provider's expenditures

(d) Receiver Fees. A receiver appointed under M.G.L. c. 111, § 72N may petition for a rate adjustment to reimburse reasonable receiver compensation and payment of his or her bond

5.12: continued

1. The receiver must submit detailed invoices that document the hours expended, a brief description of each activity, and the hourly rate. The Division will limit reimbursement to the reasonable and necessary cost to safeguard the health, safety and continuity of care to residents and to protect them from adverse health effects of unsuitable transfer.
2. The Division will limit reasonable receiver compensation to the lower of actual receiver fees or $10,000 for the first 30 days, $7,500 for the second 30 days, $2,500 for the third 30 days and $1,500 for each 30 day period thereafter. The Division may include additional receiver compensation if both the Department of Public Health and the Division of Medical Assistance approve additional compensation to the receiver due to unique circumstances. The Division, the Department, and the Division of Medical Assistance will evaluate such requests for additional compensation for reasonableness.
3. The Division will calculate a *per diem* amount to be added to the rates by dividing allowable receiver compensation by Medicaid patient days.
4. Only those expenses unique to the duties of the receiver discharged pursuant to M.G.L. c. 111, § 72N will be included as reasonable compensation under this provision. All other receivership expenses are subject to the limitations set forth in 114.2 CMR 5.05 through 5.10. When the receivership is terminated, the Division may adjust the rates to remove the costs of the receivership.

(e) Nursing Ceiling Petition. Effective October 1, 1996, facilities which demonstrate that over 75% of residents have a primary diagnosis of multiple sclerosis may request exemption from application of the nursing ceiling.

(f) Facilities in Certain Service Areas. A Provider may request an administrative adjustment if: its percentage of Medicare, Medicaid and Commission for the Blind patients to total patients is 90% or more in the year two years prior to the Petition; it is located within 2.5 miles of a sole community hospital; and more than ten percent of its Nursing and Variable Costs were disallowed. If a Nursing Facility meets these criteria, the Division will adjust the rates to reimburse the lower of the facility's total disallowed Nursing and Variable Costs, or $300,000.

(g) Geographically Isolated Facilities. Facilities which meet the criteria set forth in St. 1995, c. 39, § 48 may petition for adjustment of its allowable nursing and variable costs to reflect the costs which the Division determines to reasonably result from the facility's geographic location.

(h) Transition Petition for Public Medical Institutions. To facilitate the smooth transition of Public Medical Institutions (PMI) to the same cost limits generally applicable to all nursing facilities, a transition petition for financially threatened PMI's is provided.

A PMI may request, in writing, that the Division certify rates effective January 1, 1997 which are equal to the PMI's rates in effect on December 31, 1996. The PMI must demonstrate to the satisfaction of the Division that it meets the following criteria:

1. the impact of the 1997 reimbursement system would result in a reduction of 10% or greater in the weighted average per diem rate; and
2. the impact of the 1997 reimbursement system would result in significant financial hardship, such that the financial stability of the PMI would be threatened; and
3. the PMI was granted a petition for rates set effective January 1, 1996.

The PMI must demonstrate that all reasonable steps to control spending are being taken and that the PMI cannot rectify its financial situation by the immediate implementation of more efficient and economical operations.

114.2 CMR 5.12(5)(h) expires on December 31, 1997 at which time the rates for all PMI's will be established subject to the limits set forth in 114.2 CMR 5.00.

(6) Recommendation of Director of Bureau of Long-Term Care After review of the petition, the Director of the Bureau of Long-Term Care will report his recommendations in writing to the Commissioner of the Division and to the petitioner, stating his reasons in detail. The Provider will have ten days to file objections, arguments and comments with the Division concerning the recommendations of the Director.

5.12: continued

(7) Retroactive Reviews. The Division may require that the Provider demonstrate that the changes in costs have actually occurred and that the year-end Cost Report Substantiates the financial condition stated in the Provider's petition. If the Provider fails to provide evidence of such changes within 45 days of the Division's request, the Division may retroactively reverse the adjustment.

5.13: Special Provisions

(1) Notice of Proposed Prospective Rates.

(a) Desk Audit. Prior to certification of rates based upon a Desk Audit, the Division will send a notice of the Proposed Rates and a copy of the adjustments to the Provider at least 10 calendar days prior to the scheduled date of certification. The Provider may comment, in writing, on the Proposed Rates and adjustments during the period between the notice and the scheduled date of Division action. If the Provider requires additional time to respond, the Provider may request that the Division postpone the scheduled certification. The Provider may also request that the Division permit it to file an amended Cost Report pursuant to 114.2 CMR 5.03(6).

(b) Field Audit. In the case of rates which are amended solely to incorporate Field Audit adjustments which have been disclosed and discussed at an Exit Conference, the Division will provide a copy of the Field Audit adjustments to the Provider subsequent to the Exit Conference. The Division will not send a notice of the Proposed Rates which are based upon the Field Audit prior to their certification.

(2) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(3) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 5.00 within 30 calendar days after the Division files the rate with the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

(4) Adjustments to the Prospective Rates. The Division may at any time, adjust the Provider's rates if the Provider has reduced costs by eliminating services or transferring costs or services to other persons, entities or programs.

(5) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 5.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 5.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(6) Severability. The provisions of 114.2 CMR 5.00 are severable. If any provision of 114.2 CMR 5.00 or the application of any provision of 114.2 CMR 5.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 5.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 5.00: M.G.L. c. 118G.

(PAGES 575 THROUGH 586 ARE RESERVED FOR FUTURE USE.)